State of Kansas
Department of Social and Rehabilitation Services
Department on Aging
Kansas Health Policy Authority

Notice of Final Nursing Facility Medicaid Rates for State Fiscal Year 2012; Methodology for Calculating Final Rates, and Rate Justifications; Response to Written Comments; Notice of Intent to Amend the Medicaid State Plan

Under the Medicaid program, 42 U.S.C. 1396 et seq., the State of Kansas pays nursing facilities, nursing facilities for mental health, and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The Secretary of Aging administers the nursing facility program, which includes hospital long-term care units, and the Secretary of Social and Rehabilitation Services administers the nursing facility for mental health program. Both Secretaries act on behalf of the Kansas Health Policy Authority (KHPA), the single state Medicaid agency. As required by 42 U.S.C. 1396a(a)(13), as amended by Section 4711 of the Balanced Budget Act of 1997, P.L. No. 105-33, 101 Stat. 251, 507-08 (August 5, 1997), the Secretary of the Kansas Department on Aging (KDOA) and the Secretary of the Kansas Department of Social and Rehabilitation Services (SRS) are publishing the final Medicaid per diem rates for Medicaid-certified nursing facilities for State Fiscal Year 2012, the methodology underlying the establishment of the final nursing facility rates, and the justifications for those final rates. SRS and KDOA are also providing notice of the state's intent to submit proposed amendments to the Medicaid State Plan to the U. S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) on or before September 30, 2011.

I. Methodology Used to Calculate Medicaid Per Diem Rates for Nursing Facilities.

In general, the state uses a prospective, cost-based, facility-specific rate-setting methodology to calculate nursing facility Medicaid per diem rates, including the rates listed in this notice. The state's rate-setting methodology is contained primarily in the following described documents and authorities and in the exhibits, attachments, regulations, or other authorities referenced in them:

A. The following portions of the Kansas Medicaid State Plan are maintained by KHPA:

1. Attachment 4.19D, Part I, Subpart C, Exhibit C-1, inclusive;
2. Attachment 4.19D, Part I, Subpart J; and
3. Attachment 4.19D, Part I, Subpart K.

The text of the portions of the Medicaid State Plan identified above in section IA.1, but not the documents, authorities and the materials incorporated therein by reference, is

reprinted in this notice. The Medicaid State Plan provision set out in this notice appears in the version which the state currently intends to submit to CMS on or before September 30, 2011. The proposed Medicaid State Plan amendment that the state ultimately submits to CMS may differ from the version contained in this notice.

Copies of the documents and authorities containing the state's rate-setting methodology are available upon written request. A request for copies will be treated as a request for public records under the Kansas Open Records Act, K.S.A. 45-215 et seq. The state will charge a fee for copies. Written requests for copies should be sent to:

Secretary of Aging
New England Building, Second Floor
503 South Kansas Avenue
Topeka, KS 66603-3404
Fax Number: 785-296-0767

A.1 Attachment 4.19D, Part I, Subpart C, Exhibit C-1: Methods and Standards for Establishing Payment Rates for Nursing Facilities

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into eleven sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, and Retroactive Rate Adjustments.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

<u>Calendar Year End Cost Reports:</u>

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 129-10-17.

When a non-arms length or related party change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 129-10-17.

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2008, 2009, and 2010.

If the current provider has not submitted a calendar year report between 2008 and 2010, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 129-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to 12/31/11. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser

of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility should be considered in determining the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and per diem pass-throughs to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. Pass-throughs are explained in separate subparts of Attachment 4.19D of the State Plan. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status)

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to 12/31/11. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (IHS Index). The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to 12/31/11. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

Rates for Facilities Recognized as a Change of Provider (Change of Provider Status)

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2008 to 2010. If base cost data is not available the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the

payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to 12/31/11. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to 12/31/11. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding calendar year 2008.

All cost data used to set rates for facilities reentering the program shall be adjusted to 12/31/11. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to 12/31/11. The provider shall remain in reenrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in reenrollment status.

3) Quarterly Case Mix Index Calculation

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. Standard Version 5.12b case mix indices developed by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on

the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

The resident listing cut-off for calculating the average CMIs will be the first day of the quarter before the rate is effective. The following are the dates for the resident listings and the quarter in which the average Medicaid CMIs will be used in the quarterly rate-setting process.

Rate Effective Date:	Cut-Off Date:
July 1	April 1
October 1	July 1
January 1	October 1
April 1	January 1

The resident listings will be mailed to providers prior to the dates the quarterly case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

4) Resident Days

Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to 12/31/11. The inflation will be based on the IHS index.

The IHS Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the IHS index.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2009 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an

administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2011.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to 12/31/11. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the IHS Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	130% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the facility's cost report period CMI by the statewide average CMI for the cost report year, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are 8 million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $60 and the upper payment limit is based on 120% of the median, then the upper payment limit for the statewide average CMI would be $78 (**D**=130% x $60).

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to determine the Allowable Direct Health Care Per Diem Cost. This is the lesser of the facility's per diem cost from the base cost data period or the Direct Health Care upper payment limit. Because the direct health care costs were previously adjusted for the statewide average CMI, the Allowable Direct Health Care Per Diem Cost corresponds to the statewide average CMI.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The Medicaid CMI is divided by the statewide average CMI for the cost data period. This answer, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated quarterly to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The facility's direct health care per diem cost is $60.00, the Direct Health Care per diem limit is $78.00, and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $60.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the answer by the Allowable Direct Health Care Cost. In this case that would result in $54.00 (0.9000/1.0000 x $60.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next quarter rose to 1.1000, the Medicaid Acuity Adjustment would be $66.00 (1.1000/1.0000 x $60.00). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real And Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor. The differentiation of fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor.

The property fees in effect on June 1, 2008 were inflated with 12 months of inflation effective July 1, 2008. The inflation factor was from the IHS index. The providers receive the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated to 12/31/08 and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in (K.A.R. 30-10-25).

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in (K.A.R. 129-10-25). The rebased property fee is subject to the upper payment limit.

9) Incentive Factors

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

<u>Nursing Facility Quality and Efficiency Incentive Factor:</u>

The Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $2.50 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.25 per diem add-on. Providers that achieve a turnover rate at or below the 75th percentile will earn a $2.50 per diem add-on. Providers that have a turnover rate greater than the 75th percentile but that reduce their turnover rate by 10% or more will receive a per diem add-on of $0.25. Providers that have completed the full Kansas Culture Change Instrument Survey will receive a $0.38 per diem add-on. Finally, providers that have a Medicaid occupancy percentage of 60% or more will receive a $1.13 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

The table below summarizes the incentive factor outcomes and per diem add-ons:

INCENTIVE OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 75th percentile (4.81), or CMI adjusted staffing < 75th percentile but improved >= 10%	$2.50 $0.25
Staff turnover rate <= 75th percentile, 41% or Staff turnover rate > 75th percentile but reduced >= 10%	$2.50 $0.25
Completion of the full Kansas Culture Change Instrument Survey Medicaid occupancy >= 60%	$0.38 $1.13
Total Incentive Points Available	$6.51

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to three dollars. It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcomes measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.50, which is 120% of the statewide NFMH median of 2.92. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.21, which is 110% of the statewide NFMH median. Providers with staffing ratios below 110% of the NFMH median will receive no points for this incentive measure.

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn a point if their per diem operating expenses are below $19.49, or 90% of the statewide median of $21.66.

NFMH providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 29%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover greater than 29% but equal to or below 33%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 84%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 77%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.66) of NF-MH median (3.05), or CMI adjusted staffing ratio between 110% (3.36) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $19.14, 90% of NF-MH median, $21.27	1
Staff turnover rate <= 75th percentile, 24% Staff turnover rate <= 50th percentile, 34% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 81% Staff retention >= 50th percentile, 79%	2, or 1
Total Incentive Points Available	8

The Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

The survey and certification performance of each NF and NF-MH provider will be reviewed prior to any incentive factor payment. In order to qualify for the incentive factor a home must not have received any health care survey deficiency of scope and

severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will receive 100% of the calculated incentive factor. The survey and certification review period will be the 15-month period ending one quarter prior to the rate effective date. The following table lists the rate effective dates and corresponding review period end dates.

Rate Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 30-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

11) Retroactive Rate Adjustments

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

A.2 Attachment 4.19D, Part I, Subpart J

To compensate providers for increased expenses incurred to raise employees' wages to the new minimum wage effective July 1, 2009 ($7.25), a per diem pass-through will be determined and added on to each qualifying provider's per diem rate. The pass-through per diem will not be subject to cost center limits, and the 85% occupancy rule will not be applied to the calculation of the minimum wage pass-through.

1) Qualifying Providers

In order to qualify for the minimum wage pass-through, a provider must submit a pass-through application on the forms provided by the Kansas Department on Aging. The application will document the hourly wages of all affected employees prior to the implementation of the new minimum wage. Wage increases made prior to June 1, 2009 will not be eligible for the minimum wage pass-through. Providers will also estimate and report the number of hours each affected employee is expected to work during state fiscal year 2010 (the twelve months beginning July 1, 2009 and ending June 30, 2010). Completed applications must be returned to the Kansas Department prior to September 30, 2009.

2) Per Diem Pass-Through Calculation

The per diem pass-through will be determined by first estimating the total impact of increasing wages to the new minimum wage, and then dividing by resident days to get a per diem add-on. The total impact of increasing wages to the new minimum wage will be determined for each provider through three steps. First the incremental wage increase to the new minimum wage will be calculated for each affected employee. Second the individual impact for each affected employee will be determined by multiplying the incremental wage increase by the estimated hours each affected employee is expected to work during fiscal year 2010. Finally the total impact of the minimum wage increase for each provider will be the sum of the individual impacts determined for each employee. A per diem pass-through add-on will then be calculated by dividing each provider's estimated total impact by the provider's most recent cost report resident day total.

As an example, consider an employer that has ten employees receiving a wage of $6.75 prior to July 1, 2009. If the employer raises their wages effective July 1, 2009, the incremental wage increase due to the new minimum wage will be $0.50. If each employee is expected to work 2,000 hours during fiscal year 2010, the total impact per employee will be $1,000 ($0.50 x 2,000 hrs). The total estimated impact for the provider will be $10,000 ($1,000 x 10). If the employer provided 10,000 resident days during the most recent cost report, the pass-through per diem will be $10,000/10,000 days, or $1.00.

3) Per Diem Limits

No per diem add-on will be implemented that is not equal to or greater than $0.10.

4) Effective Dates

Pass-through applications received prior to June 30, 2009 will be effective July 1, 2009. After that date, each provider's per diem pass-through will be effective on the first day of the month following the receipt of a completed application. No pass-through per diems will be implemented after October 1, 2009.

5) Phasing Out the Pass-Through

The per diem pass-through will be phased out as the effects of the minimum wage increase are reflected in the cost reports. The pass-through per diems will be adjusted on a facility-specific basis to reflect the ratio of cost data that includes the new minimum wage costs.

During the phasing out of the minimum wage pass-through, if the per diem add-on falls below $0.10, it will be removed from the rate calculation.

6) Auditing and Adjustments

Each qualifying providers' application and supporting documentation for the minimum wage pass-through will be subject to desk review and field audit and may by revised based on those findings. Corrections that result in a $0.10 or greater per diem change to the pass-through will be implemented. Retroactive rate adjustments will be made when necessary.

A.3 Attachment 4.19D, Part I, Subpart K

To compensate providers for increased expenses incurred due to the transfer of responsibility for all durable medical equipment to the nursing home program, a per diem pass-through will be determined and added on to each provider's per diem rate. The pass-through per diem will not be subject to cost center limits, and the 85% occupancy rule will not be applied to the calculation of the DME pass-through.

1) Qualifying Providers

All providers with costs reported on line 507 of the Medicaid cost report will be eligible to receive the DME pass-through.

2) Per Diem Pass-Through Calculation

The per diem pass-through will be determined by dividing the inflated unadjusted costs reported on line 507 for the base cost data period effective July 1, 2008, by the non-Medicaid days reported for the same period. Non-Medicaid resident days will be determined by subtracting Medicaid resident days from total resident days.

As an example, consider a provider that reported $1,000 on line 507 for each year in the base cost data period from 2005 through 2007. The cost will first be inflated for each year based on the DRI factors applied to cost data used to determine the base reimbursement rates. For 2005 the inflated cost would be $1,134, for 2006 the inflated costs would be $1,089, and for 2007 the inflated costs would be $1,055. The total inflated costs would be $3,278. If the provider reported 30,000 resident days during the base cost data period and 20,000 Medicaid days, the non-Medicaid resident day total would be 10,000 (30,000 – 20,000). The DME pass-through per diem would then be $0.33 ($3,278 / 10,000 rounded to the nearest hundredth).

3) Per Diem Limits

No per diem add-on will be implemented that is not equal to or greater than $0.10.

4) Effective Dates

The durable medical equipment pass-through will be effective July 1, 2008.

5) Phasing Out the Pass-Through

The per diem pass-through will be phased out as the effects of transferring responsibility for all DME to the nursing home program are reflected in the cost reports.

The pass-through per diems will be adjusted on a facility-specific basis to reflect the ratio of cost data that includes the new DME expenses.

During the phasing out of the DME pass-through, if the per diem add-on falls below $0.10, it will be removed from the rate calculation.

6) Auditing and Adjustments

Each qualifying providers' cost report and supporting documentation used to determine the DME pass-through will be subject to desk review and field audit and may by revised based on those findings. Corrections that result in a $0.10 or greater per diem change to the pass-through will be implemented. Retroactive rate adjustments will be made when necessary.

II. Proposed Medicaid Per Diem Rates for Kansas Nursing Facilities

A. Cost Center Limitations: The state proposes the following cost center limitations which are used in setting rates effective July 1, 2011.

Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	$31.59
Indirect Health Care	115% of the Median Cost	$45.82
Direct Health Care	130% of the Median Cost	$99.13
Real and Personal Property Fee	105% of the Median Fee	$9.14

These amounts were determined according to the "Reimbursement Limitations" section. The Direct Healthcare Limit is calculated based on a CMI of 1.0124, which is the statewide average.

B. Case Mix Index. These proposed rates are based upon each nursing facility's Medicaid average CMI calculated with a cutoff date of April 1, 2011, using the July 1,

2011 Kansas Medicaid/Medikan CMI Table. In Section II.C below, each nursing facility's Medicaid average CMI is listed beside its proposed per diem rate.

C. Proposed Nursing Facility Per Diem Rates and CMI.

The following list includes the calculated Medicaid rate for each nursing facility provider currently enrolled in the Medicaid program and the Medicaid case mix index used to determine each rate.

Provnum	Facility Name	City	Daily Rate	Medicaid CMI
19928	Village Manor	Abilene	154.22	0.9149
20875	Alma Manor	Alma	156.67	0.8310
11211	Life Care Center of Andover	Andover	150.61	1.1213
19671	Anthony Community Care Center	Anthony	148.41	1.1013
18691	Medicalodges Health Care Ctr Arkans	Arkansas City	157.58	0.9709
19387	Arkansas City Presbyterian Manor	Arkansas City	161.05	0.9692
19244	Deseret Nursing & Rehab at Arma, Inc	Arma	131.95	1.1027
15157	Ashland Health Center - LTCU	Ashland	189.31	1.0757
10826	Medicalodges Atchison	Atchison	167.04	1.0704
15023	Atchison Senior Village	Atchison	158.99	0.9215
21222	Dooley Center	Atchison	159.31	0.6958
05720	Attica Long Term Care	Attica	158.63	0.9745
26464	Good Samaritan Society-Atwood	Atwood	159.49	0.9279
15113	Lake Point Nursing Center	Augusta	133.73	0.9454
15363	Baldwin Care Center	Baldwin City	138.31	1.0706
20919	Quaker Hill Manor	Baxter Springs	123.61	1.0627
10646	Catholic Care Center Inc.	Bel Aire	166.24	0.9574
05415	Great Plains of Republic County, Inc	Belleville	193.60	1.0818
18502	Belleville Health Care Center	Belleville	128.25	1.0062
05516	Mitchell County Hosptial LTCU	Beloit	176.46	0.9006
11467	Hilltop Lodge Nursing Home	Beloit	151.48	0.9871
20732	Bonner Springs Nursing and Rehabilit	Bonner Springs	144.71	1.0482
15462	Hill Top House	Bucklin	156.36	0.9827
26565	Buhler Sunshine Home, Inc.	Buhler	173.36	1.0096
16780	Life Care Center of Burlington	Burlington	133.84	0.9970
20676	Caney Nursing Center	Caney	109.05	0.9917
21132	Eastridge Nursing Home	Centralia	152.63	0.7467
11144	Heritage Health Care Center	Chanute	132.89	1.0842
20146	Chanute Health Care Center	Chanute	147.98	1.0090
20942	Applewood Rehabilitation	Chanute	80.18	0.7768
16845	Chapman Valley Manor	Chapman	130.29	0.8855
16351	Cheney Golden Age Home Inc.	Cheney	145.61	0.9677
21009	Cherryvale Care Center	Cherryvale	127.24	0.9963
19019	Chetopa Manor	Chetopa	118.47	0.8875
18308	The Shepherd's Center	Cimarron	147.49	0.9893
11107	Medicalodges Clay Center	Clay Center	167.60	0.9546
15168	Clay Center Presbyterian Manor	Clay Center	181.47	0.9688
16417	Clearwater Ret. Community	Clearwater	167.19	1.0269
20266	Community Care, Inc.	Clifton	110.95	0.7950
17813	Park Villa Nursing Home	Clyde	131.10	0.9106

05764	Coffeyville Regional Medical Center	Coffeyville	89.58	0.0000
11514	Windsor Place	Coffeyville	145.80	1.0112
15991	Medicalodges Coffeyville	Coffeyville	173.10	1.1000
19917	Windsor Place at Iola, LLC	Coffeyville	148.67	0.9974
19119	Deseret Nursing & Rehab at Colby	Colby	159.81	1.1178
19648	Prairie Senior Living Complex	Colby	173.20	0.9669
25251	Pioneer Lodge	Coldwater	139.49	0.8339
18410	Medicalodges Columbus	Columbus	172.00	1.1233
15226	Mt Joseph Senior Village, LLC	Concordia	137.34	1.0607
21187	Sunset Home, Inc.	Concordia	148.74	0.9985
27217	Spring View Manor	Conway Springs	120.59	0.9163
19872	Golden Living Center-Chase Co.	Cottonwood Falls	134.51	0.9826
20135	Council Grove Healthcare Center	Council Grove	141.96	1.0558
18162	Hilltop Manor	Cunningham	122.85	0.9859
10748	Westview of Derby	Derby	147.55	1.0083
21560	Derby Health and Rehabilitation	Derby	191.42	1.0710
20492	Hillside Village	DeSoto	137.68	0.9188
18173	Dexter Care Center	Dexter	127.46	0.8571
05347	Lane County Hospital - LTCU	Dighton	167.29	0.9367
11377	Trinity Manor	Dodge City	152.23	1.0165
17385	Good Samaritan Society-Dodge City	Dodge City	150.50	1.0197
21143	Manor of the Plains	Dodge City	165.61	1.0467
20838	Medicalodges Douglass	Douglass	166.93	1.0088
10995	Golden Living Center-Downs	Downs	134.29	1.0129
19153	Country Care Home	Easton	134.75	0.8496
20614	Golden Living Center-Parkway	Edwardsville	145.04	1.0328
20625	Golden Living Center-Kaw River	Edwardsville	157.85	0.9870
20636	Golden Living Center-Edwardsville	Edwardsville	132.65	0.8279
10782	Lakepoint Nursing Center-El Dorado	El Dorado	140.76	1.1338
19907	Golden Living Center-El Dorado	El Dorado	139.86	1.1335
05696	Morton County Hospital	Elkhart	140.35	0.9327
19635	Woodhaven Care Center	Ellinwood	135.88	1.0204
25485	Good Samaritan Society-Ellis	Ellis	164.18	1.0592
15416	Good Sam Society-Ellsworth Village	Ellsworth	152.50	0.9971
11232	Emporia Presbyterian Manor	Emporia	181.55	1.0200
11367	Holiday Resort	Emporia	130.67	0.9569
20175	Flint Hills Care Center, Inc.	Emporia	109.26	0.8833
17791	Enterprise Estates Nursing Center, I	Enterprise	129.30	0.9474
20715	Golden Living Center-Eskridge	Eskridge	109.94	0.8091
17781	Medicalodges of Eudora	Eudora	136.20	0.8766
18927	Eureka Nursing Center	Eureka	134.02	0.9926
21570	Kansas Soldiers' Home	Fort Dodge	159.67	0.8745
15045	Medicalodges Fort Scott	Fort Scott	158.25	0.9677
20446	Fort Scott Manor	Fort Scott	121.48	0.8764
17857	Fowler Residential Care	Fowler	166.78	0.9038
27555	Frankfort Community Care Home, Inc.	Frankfort	144.74	1.0284
20581	Golden Living Center-Fredonia	Fredonia	135.58	1.0439
15304	Sunset Manor, Inc	Frontenac	123.82	0.9820
17915	Emerald Pointe Health & Rehab	Galena	117.84	0.8336

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20930	Galena Nursing & Rehab Center	Galena	125.27	0.9090
11345	Garden Valley Retirement Village	Garden City	154.25	1.0071
15430	Homestead Health & Rehab	Garden City	153.90	0.8974
05712	Meadowbrook Rehab Hosp., LTCU	Gardner	191.48	1.0778
19579	Medicalodges Gardner	Gardner	151.21	0.9622
05808	Anderson County Hospital	Garnett	174.92	0.9612
21053	Golden Heights Living Center	Garnett	145.97	0.9163
15315	The Heritage	Girard	124.68	1.1096
15214	The Nicol Home, Inc.	Glasco	133.55	0.9000
11197	Medicalodges Goddard	Goddard	171.74	1.0394
05595	Bethesda Home	Goessel	186.85	1.0672
17295	Good Samaritan Society-Sherman C	Goodland	153.19	0.9539
10714	Cherry Village Benevolence	Great Bend	130.91	0.8733
16836	Great Bend Health & Rehab Center	Great Bend	141.57	1.0416
11029	Halstead Health and Rehab Center	Halstead	136.83	0.8687
20120	Lakewood Senior Living of Haviland	Haviland	94.90	0.6989
11006	St. John's of Hays	Hays	146.43	0.9219
17137	St. Johns Victoria	Hays	149.75	0.9759
17486	Good Samaritan Society-Hays	Hays	139.33	0.9527
11089	Haysville Healthcare Center	Haysville	156.20	1.0482
15348	Medicalodges Herington	Herington	138.48	0.9647
16902	Schowalter Villa	Hesston	185.97	0.9564
21032	Maple Heights of Hiawatha	Hiawatha	125.39	0.9309
19334	Highland Care Center	Highland	131.34	0.9425
25531	Dawson Place, Inc.	Hill City	154.21	0.9338
05426	Salem Home	Hillsboro	159.65	0.8719
17690	Parkside Homes, Inc.	Hillsboro	163.23	1.0935
17835	Medicalodges Jackson County	Holton	143.92	0.9438
10602	Tri County Manor Living Center, Inc.	Horton	116.28	0.9795
15394	Howard Twilight Manor	Howard	146.39	1.0378
05281	Sheridan County Hospital	Hoxie	154.23	0.8745
11018	Pioneer Manor	Hugoton	178.24	0.9004
20821	Pinecrest Nursing Home	Humboldt	144.38	0.8879
11076	Golden Plains	Hutchinson	132.31	0.9248
17148	Good Sam Society-Hutchinson Village	Hutchinson	170.68	1.0702
19595	Hutchinson Care Center	Hutchinson	129.02	0.9154
21154	Wesley Towers	Hutchinson	190.80	1.0655
21176	Ray E. Dillon Living Center	Hutchinson	178.39	0.9887
11447	Regal Estate	Independence	122.54	1.0181
19309	Windsor Place at Independence	Independence	145.23	0.9920
25913	Pleasant View Home	Inman	157.71	0.8940
15002	Iola Nursing Center	Iola	145.32	1.0563
05066	Hodgeman Co Health Center-LTCU	Jetmore	174.28	0.9570
05674	Stanton County Hospital- LTCU	Johnson	184.46	1.0143
10480	Valley View Senior Life	Junction City	155.12	0.9897
10591	Medicalodges Post Acute Care Center	Kansas City	173.91	1.1300
11030	Kansas City Presbyterian Manor	Kansas City	182.24	0.9742
16654	Medicalodges Kansas City	Kansas City	163.87	0.9883
20377	Lifecare Center of Kansas City	Kansas City	152.43	1.0572

20244	Deseret Nursing & Rehab at Kensingto	Kensington	130.10	1.1138
21121	The Wheatlands	Kingman	139.78	0.9553
18432	Medicalodges Kinsley	Kinsley	176.26	0.9076
20806	Kiowa Hospital District Manor	Kiowa	157.41	0.8418
05246	Rush Co. Memorial Hospital	La Crosse	169.92	1.0756
18757	Rush County Nursing Home	Lacrosse	156.37	1.0273
20232	High Plains Retirement Village	Lakin	186.66	1.0424
20197	Golden Living Center-Lansing	Lansing	145.24	1.0459
20450	Larned Healthcare Center	Larned	139.12	0.9669
11175	Lawrence Presbyterian Manor	Lawrence	181.86	1.0717
11391	Brandon Woods at Alvamar	Lawrence	173.59	0.9319
21450	Pioneer Ridge Retirement Community	Lawrence	157.85	0.9138
11096	Medicalodges Leavenworth	Leavenworth	155.50	0.9142
11355	Delmar Gardens of Lenexa	Lenexa	139.84	0.9381
21470	Lakeview Village	Lenexa	185.07	1.0038
16261	Leonardville Nursing Home	Leonardville	127.92	0.9531
05786	Wichita County Health Center	Leoti	149.91	0.6700
17508	Good Samaritan Society-Liberal	Liberal	154.37	1.0638
21510	Wheatridge Park Care Center	Liberal	153.74	0.9291
17577	Lincoln Park Manor, Inc.	Lincoln	142.10	0.9873
15890	Bethany Home Association	Lindsborg	175.69	0.9409
17352	Linn Community Nursing Home	Linn	131.58	1.0296
27566	Sandstone Heights	Little River	176.14	1.0194
17328	Logan Manor Community Health Service	Logan	179.70	1.0190
20096	Louisburg Care Center	Louisburg	142.98	1.0860
17497	Good Samaritan Society-Lyons	Lyons	157.52	1.0224
10894	Meadowlark Hills Retirement Communit	Manhattan	195.01	1.0841
11491	Stoneybrook Retirement Community	Manhattan	164.92	0.9777
21530	St. Joseph Village, Inc.	Manhattan	153.92	0.9845
05088	Jewell County Hospital	Mankato	178.88	0.9850
05156	St. Luke Living Center	Marion	145.41	0.8985
18037	Riverview Estates, Inc.	Marquette	140.98	0.8113
21162	Cambridge Place	Marysville	133.08	0.9354
20854	McPherson Care Center	Mcpherson	130.60	1.1610
25935	The Cedars, Inc.	Mcpherson	168.91	0.9162
25982	Meade District Hospital, LTCU	Meade	174.37	0.8750
10805	Trinity Nursing & Rehab Ctr	Merriam	164.49	1.1045
05191	Great Plains of Ottawa County, Inc.	Minneapolis	132.45	0.8433
17734	Good Samaritan Society-Minneapolis	Minneapolis	148.50	1.0784
18274	Minneola District Hospital	Minneola	180.33	0.9513
15528	Bethel Home, Inc.	Montezuma	152.53	0.8794
20085	Moran Manor	Moran	126.58	1.1384
15901	Memorial Home for the Aged	Moundridge	168.54	0.9666
18140	Moundridge Manor, Inc.	Moundridge	149.95	0.8288
17565	Mt. Hope Nursing Center	Mt. Hope	138.56	0.9609
18230	Villa Maria, Inc.	Mulvane	136.58	0.9271
20605	Golden Living Center-Neodesha	Neodesha	135.99	1.0971
05630	Ness County Hospital Dist.#2	Ness City	168.85	0.9711

10062	Asbury Park	Newton	176.31	0.9741
15574	Kansas Christian Home	Newton	161.47	0.9896
15585	Newton Presbyterian Manor	Newton	182.04	0.9579
10051	Bethel Care Center	North Newton	164.19	0.9648
16103	Andbe Home, Inc.	Norton	150.14	0.9764
15619	Village Villa	Nortonville	140.39	1.1120
19683	Logan County Manor	Oakley	175.65	0.9128
05562	Decatur County Hospital	Oberlin	170.32	1.0208
25395	Good Samaritan Society-Decatur Co.	Oberlin	151.11	0.9208
10668	Villa St. Francis	Olathe	174.42	1.0412
10920	Pinnacle Ridge Nursing and Rehabilit	Olathe	145.14	1.0036
11245	Royal Terrace Nrsg. & Rehab. Center	Olathe	137.12	0.9270
15653	Good Samaritan Society-Olathe	Olathe	173.64	0.9922
21109	Evergreen Community of Johnson Count	Olathe	194.70	1.0861
21460	Aberdeen Village, Inc.	Olathe	181.25	0.9058
26422	Deseret Nursing & Rehab at Onaga	Onaga	125.85	1.0838
18206	Peterson Health Care, Inc.	Osage City	127.05	0.9691
27578	Osage Nursing & Rehab Center	Osage City	148.55	1.1032
10973	Life Care Center of Osawatomie	Osawatomie	151.11	1.1173
17521	Parkview Care Center	Osborne	129.32	0.8688
20301	Hickory Pointe Care & Rehab Ctr	Oskaloosa	146.19	0.9420
18402	Deseret Nursing & Rehab at Oswego	Oswego	118.39	1.0238
20467	Ottawa Retirement Village	Ottawa	136.21	1.0640
11121	Brookside Manor	Overbrook	129.65	0.8906
11300	Garden Terrace at Overland Park	Overland Park	152.72	1.0235
11335	Indian Meadows Healthcare Center	Overland Park	186.49	1.3350
11412	Manorcare Hlth Services of Overland	Overland Park	179.69	1.1048
11423	Villa Saint Joseph	Overland Park	188.00	1.0456
11478	Delmar Gardens of Overland Park	Overland Park	169.25	0.9721
21200	Overland Park Nursing & Rehab	Overland Park	160.87	0.9432
21251	Indian Creek Healthcare Center	Overland Park	172.23	1.1157
21430	Village Shalom, Inc.	Overland Park	184.88	0.9429
16553	Riverview Manor, Inc.	Oxford	113.30	0.8929
18713	Medicalodges Paola	Paola	111.67	0.7015
20298	North Point Skilled Nursing Center	Paola	143.88	1.0571
18322	Elmhaven East	Parsons	125.07	1.0163
18792	Elmhaven West	Parsons	132.79	0.9700
18871	Parsons Presbyterian Manor	Parsons	165.98	0.9761
25733	Good Samaritan Society-Parsons	Parsons	148.14	1.0174
10096	Legacy Park	Peabody	145.00	0.9352
20753	Westview Manor of Peabody	Peabody	80.29	0.6502
21045	Phillips County Retirement Center	Phillipsburg	129.96	0.9723
10433	Medicalodges Pittsburg South	Pittsburg	166.16	1.1290
11401	Mt. Carmel Regional Medical Ctr. SNF	Pittsburg	87.43	0.0000
20749	Golden Living Center-Pittsburg	Pittsburg	133.98	1.0710
21520	Cornerstone Village, Inc.	Pittsburg	142.39	0.9243
26666	Rooks County Senior Services, Inc.	Plainville	162.78	0.9437
05775	Pratt Regional Medical Center	Pratt	179.51	1.0547
20028	Lakewood Senior Living of Pratt, LLC	Pratt	144.18	1.1104
17464	Prescott Country View Nursing Center	Prescott	132.45	1.1040

21440	Prairie Sunset Manor	Pretty Prairie	147.53	0.8438
17587	Protection Valley Manor	Protection	126.54	0.8477
05044	Gove County Medical Center	Quinter	172.52	0.8977
05617	Grisell Memorial Hosp Dist #1-LTCU	Ransom	170.65	0.9650
15485	Richmond Healthcare and Rehabilitati	Richmond	150.67	1.0545
20695	Lakepoint Nursing Ctr-Rose Hill	Rose Hill	146.35	1.0604
18445	Rossville Healthcare & Rehab Center	Rossville	135.10	0.9939
20772	Wheatland Nursing & Rehab Center	Russell	134.63	0.9819
21480	Russell Regional Hospital	Russell	214.13	1.2463
19782	Sabetha Nursing Center	Sabetha	155.59	1.2090
26238	Apostolic Christian Home	Sabetha	138.30	0.9320
10774	Smokey Hill Rehabilitation Center	Salina	132.77	1.0055
10952	Kenwood View Nursing Center	Salina	128.44	0.9454
11186	Windsor Estates	Salina	136.89	1.0057
11459	Pinnacle Park Nursing and Rehabilita	Salina	125.03	1.0339
11480	Salina Presbyterian Manor	Salina	182.36	1.0040
21382	Holiday Resort of Salina	Salina	143.31	0.9296
05685	Satanta Dist. Hosp. LTCU	Satanta	173.96	0.9329
16338	Park Lane Nursing Home	Scott City	160.81	0.9166
19545	Pleasant Valley Manor	Sedan	118.95	1.0437
19707	Sedgwick Healthcare Center	Sedgwick	161.77	0.9706
16037	Crestview Manor	Seneca	113.50	0.9575
18253	Life Care Center of Seneca	Seneca	129.58	0.9855
27263	Good Samaritan Society	Sharon Springs	150.25	1.0386
15384	Shawnee Gardens Nursing Center	Shawnee	145.21	1.1619
21190	Sharon Lane Health Services	Shawnee	140.24	1.0082
05505	Smith County Memorial Hospital LTCU	Smith Center	164.49	0.8357
18153	Deseret Nursing & Rehab at Smith Ctr	Smith Center	130.18	1.1188
18138	Mennonite Friendship Manor, Inc.	South Hutchinson	177.38	0.9807
20650	Golden Living Center-Spring Hill	Spring Hill	161.30	1.1393
25204	Good Sam Society-St. Francis Village	St. Francis	154.81	0.8733
19884	Leisure Homestead at St. John	St. John	148.68	0.9765
19467	Community Hospital of Onaga, LTCU	St. Mary's	174.80	0.9590
21240	Prairie Mission Retirement Village	St. Paul	138.73	0.9694
17655	Leisure Homestead at Stafford	Stafford	125.81	0.8812
26622	Sterling Presbyterian Manor	Sterling	164.36	0.8207
20222	Solomon Valley Manor	Stockton	170.19	1.1189
05641	Seasons of Life Living Center	Syracuse	163.95	0.8447
11154	Tonganoxie Nursing Center	Tonganoxie	150.99	1.0586
10310	Brewster Place	Topeka	180.53	0.9525
10343	Topeka Presbyterian Manor Inc.	Topeka	180.66	0.9638
10916	Eventide Convalescent Center, Inc.	Topeka	120.36	0.8367
11201	Topeka Community Healthcare Center	Topeka	146.90	1.0057
11254	McCrite Plaza Health Center	Topeka	146.90	0.8946
11276	Rolling Hills Health Center	Topeka	172.75	1.0094
11388	Manorcare Health Services of Topeka	Topeka	157.53	1.0306
19346	Westwood Manor	Topeka	134.46	0.9736
19445	IHS of Brighton Place	Topeka	96.75	0.6731
19692	Countryside Health Center	Topeka	110.74	0.6854
20557	Providence Living Center	Topeka	94.75	0.7156

20963	Brighton Place North	Topeka	91.89	0.6544
21110	Aldersgate Village	Topeka	179.94	1.0013
21211	Plaza West Care Center, Inc.	Topeka	173.15	1.0106
21420	Lexington Park Nursing and Post Acut	Topeka	165.94	0.9195
18772	Greeley County Hospital, LTCU	Tribune	180.76	0.9800
21590	The Legacy at Park View	Ulysses	163.42	0.9124
18465	Valley Health Care Center	Valley Falls	120.28	0.6453
05292	Trego Co. Lemke Memorial LTCU	Wakeeney	168.83	0.8717
20865	Trego Manor	Wakeeney	150.96	0.9438
20704	Golden Living Center-Wakefield	Wakefield	156.96	1.0672
26442	Good Samaritan Society-Valley Vista	Wamego	158.60	0.9665
16597	The Centennial Homestead, Inc.	Washington	115.63	0.8367
20186	Wathena Nursing & Rehab Center	Wathena	145.04	1.0281
20076	Coffey County Hospital	Waverly	163.77	0.8617
19863	Golden Living Center-Wellington	Wellington	128.95	0.9858
20368	Deseret Nursing & Rehab at Wellingto	Wellington	128.93	1.1296
20392	Wellsville Manor	Wellsville	122.54	0.8638
17767	Westy Community Care Home	Westmoreland	131.93	0.9700
10578	Wheat State Manor	Whitewater	159.23	0.9633
10141	Medicalodges Wichita	Wichita	159.34	0.9730
10613	Meridian Nursing & Rehab Center	Wichita	125.08	0.9121
10670	Kansas Masonic Home	Wichita	174.67	1.0475
10736	Homestead Health Center, Inc.	Wichita	174.23	1.0225
10853	Deseret Nursing & Rehab at Wichita	Wichita	135.66	1.1942
11052	Wichita Presbyterian Manor	Wichita	177.79	0.9720
11266	Sandpiper Healthcare and Rehab Cente	Wichita	138.07	1.0173
11313	Lakepoint Nursing and Rehabilitation	Wichita	147.07	0.9795
11322	Manorcare Health Services of Wichita	Wichita	161.62	1.1122
11504	College Hill Nursing and Rehab Cente	Wichita	143.58	0.9600
18582	Lakewood Senior Living of Seville	Wichita	138.78	0.9639
18591	Golden Living Center-Wichita	Wichita	141.61	0.9060
18784	Wichita Nursing Center	Wichita	99.90	0.8040
21233	The Health Care Center@Larksfield Pl	Wichita	159.66	0.9343
21360	Life Care Center of Wichita	Wichita	154.34	1.1013
21541	Via Christi Hope	Wichita	128.39	0.9278
21550	Family Health & Rehabilitation Cente	Wichita	162.02	0.9667
20660	Golden Living Center-Wilson	Wilson	144.50	1.1810
05584	Jefferson Co. Memorial Hospital-LTCU	Winchester	156.58	0.9739
16812	Good Samaritan Society-Winfield	Winfield	149.64	1.0005
21350	Cumbernauld Village, Inc.	Winfield	178.61	0.9410
21410	Winfield Rest Haven, Inc.	Winfield	155.89	0.8985
21580	Kansas Veterans' Home	Winfield	157.46	0.9629
20335	Deseret Nursing & Rehab at Yates Ctr	Yates Center	136.43	1.0850

III. Justifications for the Proposed Rates

1. The proposed rates are calculated according to the rate-setting methodology in the Kansas Medicaid State Plan and pending amendments thereto.

2. The proposed rates are calculated according to a methodology which satisfies the requirements of K.S.A. 39-708c(x) and the KHPA regulations in K.A.R. Article 30-10 implementing that statute and applicable federal law.

3. The State's analyses project that the proposed rates:
   a. Would result in payment, in the aggregate of 95.4% of the Medicaid day weighted average inflated allowable nursing facility costs statewide; and
   b. Would result in a maximum allowable rate of $185.68; with the total average allowable cost being $162.60.

c.	Estimated average rate July 1, 2011	$149.10
d.	Average payment rate July 1, 2010	$145.44
	Amount of change	$3.66
	Percent of change	2.51%

4. Estimated annual aggregate expenditures in the Medicaid nursing facility services payment program will increase approximately $11 million.

5. The state estimates that the proposed rates will continue to make quality care and services available under the Medicaid State Plan at least to the extent that care and services are available to the general population in the geographic area. The state's analyses indicate:

   a. Service providers operating a total of 285 nursing facilities (representing 97% of all the licensed nursing facilities in Kansas) participate in the Medicaid program, while an additional 39 hospital-based long-term care units are also certified to participate in the Medicaid program;

   b. There is at least one Medicaid-certified nursing facility and/or nursing facility for mental health, or Medicaid-certified hospital-based long-term care unit in 105 of the 105 counties in Kansas;

   c. The statewide average occupancy rate for nursing facilities participating in Medicaid is 83.82%;

   d. The statewide average Medicaid occupancy rate for participating facilities is 56.38%; and

   e. The proposed rates would cover 96.6% of the estimated Medicaid direct health care costs incurred by participating nursing facilities statewide.

6. Federal Medicaid regulations at 42 C.F.R. 447.272 impose an aggregate upper payment limit that states may pay for Medicaid nursing facility services. The state's analysis indicates that the proposed methodology will result in compliance

with the federal regulation.

IV. Request for Comments; Request for Copies

The state requests providers, beneficiaries and their representatives, and other concerned Kansas residents to review and comment on the proposed rates, the methodology used to calculate the proposed rates, the justifications for the proposed rates, and the intent to amend the Medicaid State Plan. Persons and organizations wishing to submit comments must mail, deliver, or fax their signed, written comments before the close of business on Friday, May 27, 2011 to:

Amanda Barta
Nursing Facility Reimbursement Manager
Kansas Department on Aging
New England Building, Second Floor
503 South Kansas Avenue
Topeka, KS 66603-3404 Fax Number: 785-296-0256

V. Notice of Intent to Amend the Medicaid State Plan

The state intends to submit proposed Medicaid State Plan amendments to CMS on or before September 30, 2011.

Shawn Sullivan
Secretary of Aging
Kansas Department on Aging

Rod Siedlecki
Secretary
Kansas Department of Social and
Rehabilitation Services

Dr. Andrew Allison
Executive Director
Kansas Health Policy Authority